

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

JAKE V.

Claimant,

vs.

REDWOOD COAST REGIONAL CENTER,

Service Agency.

OAH No. N 2005110247

DECISION

Administrative Law Judge Nancy L. Rasmussen, Office of Administrative Hearings, State of California, heard this matter on April 11, 2006, in Eureka, California.

James Stoepler, Esq., Office of Clients Rights Advocacy, Protection & Advocacy, Inc., represented claimant Jake V.

Director of Clinical Services Patrick B. Okey represented service agency Redwood Coast Regional Center.

The record was held open for the parties to submit post-hearing briefs. On April 27, 2006, claimant's closing brief was received by facsimile transmission. The original of that document was marked as Exhibit C for identification when it was received on May 1, 2006. On May 17, 2006, service agency's closing brief was received by facsimile transmission. The original of that document was marked as Exhibit 2 for identification when it was received on May 27, 2006. On June 28, 2006, claimant's reply brief was received by facsimile transmission, and it was marked as Exhibit D for identification.¹ On June 28, 2006, the record was closed and the matter was deemed submitted.

¹ In his cover sheet, Mr. Stoepler explained that he had previously sent this brief on June 9, 2006, and the administrative law judge's voice mail message informing him that she had not received the brief had been left when he was on vacation.

ISSUE

Is claimant eligible for regional center services by reason of mental retardation, or a condition similar to mental retardation or requiring treatment similar to that required by mentally retarded individuals?

FACTUAL FINDINGS

1. Claimant Jake V. is a 15-year-old boy who has applied for services from Redwood Coast Regional Center (RCRC). Claimant resides with his parents and two older brothers in Fortuna.

2. Claimant reached all developmental milestones on time, but from early on, he had behavioral and social problems. He has been in resource classes since kindergarten. In his Confidential Multidisciplinary Special Education Report Comprehensive Evaluation, dated August 31, 2005, school psychologist Leon H. Kent described claimant's earlier assessments as follows:

When Jake first started school in Los Angeles, he was having severe behavioral and social problems. He was assessed by the school in 1996 at age 5 years six months. At that time he had scores on the Preschool Team Assessment Scales of 48 months in Verbal, and 47 months in Readiness. His cognitive skills were within the average range as measured through an alternative assessment. The strength was in conceptualization in both verbal and non-verbal skills. The area of short term memory was identified as the weakness. A disorder in attention was also identified. On the BASC² he had scores which suggested difficulty with worries, easily disappointed and frustrated, and verbalized many negative thoughts. He was placed in special education with an eligibility of Specific Learning Disability.

He was again assessed in 1999 while attending second grade at Redway. That assessment yielded scores on the WISC III³ of Verbal Score 79, Performance Score 89, and a full scale IQ of 82. That score would be considered to be within the low average range of intelligence. On the Woodcock Johnson-Revised, he had standard scores of 75 in Math, 90 in Written Language, and 103 in Reading. The eligibility for special

² Behavior Assessment System for Children.

³ Wechsler Intelligence Scale for Children – Third Edition.

education at that time was Speech and Language, and Other Health Impaired (ADHD).

The Woodcock-Johnson-R was also administered in 2000 and his scores were somewhat higher than in 1999.

The next testing was in 2002, while he was in the fifth grade in Redway. The School Psychologist had concerns regarding Jake's emotional status and behavioral changes at school. The report suggests that Jake was having many crying episode[s] at school, hyperventilating, becoming rigid when approached, and excessive agitation and frustration. The mother provided a report to the teacher which indicated her concerns with Jake and a knife incident in the home. The teacher was concerned for the safety of Jake. At that time he was seeing Dr. Soper, Psychiatrist, and had a diagnosis of Obsessive Compulsive Disorder, ADHD, and possibly Bipolar. He was taking Luvox, and Resperdal [sic] at the time.

The Woodcock-Johnson III was also administered and the standard scores were beginning to drop significantly. The cognitive scores were beginning to diminish also as seen on the WISC-III. His verbal score was 74, performance of 72, and a full scale IQ of 71. Over a period of five years his IQ dropped by almost 30 points. But, his overall emotional status was diminishing also.

The Speech and Language therapist also provided testing information which suggested significant difficulty in understanding language, using language, and sustained delays in responding. Test scores on the CELF-3⁴ were standard scores of 72 in receptive language, 74 in expressive language, and a total test score of 74. On the Peabody Picture Vocabulary Test III, he had scores within the average range.

3. Claimant's behavioral problems have escalated in the last few years, as he has grown bigger, stronger and more assertive. He also started using marijuana, alcohol and tobacco. Claimant is sensitive to caffeine, which he sometimes consumes in quantities that cause him to become hypomanic. He has had problems with impulsivity, anxiety, low frustration tolerance, and a preoccupation with negative thoughts. He is insensitive to the needs of others, and can be combative, obsessive and annoying. Although claimant's

⁴ Clinical Evaluation of Language Fundamentals – Third Edition.

behavior improved during the eighth grade (2005-06), his family had before that called the police many times when claimant was physically or verbally threatening members of the family. Once, while under the influence of alcohol, claimant physically attacked his father. This resulted in claimant being placed on informal probation and having to perform community service.

During the sixth and seventh grades, claimant's misbehavior at school resulted in disciplinary action being taken against him on several occasions. He was suspended for threatening another student and using racial slurs. On other occasions, claimant was disciplined for pushing students, wearing his hat in class, using inappropriate language, and hitting a student. His special education teacher found claimant to be unpredictable and inconsistent in his behavior.

During the seventh grade, a one-to-one Special Circumstance Instructional Aide worked with claimant three and one-half hours per day. He often had to remove claimant from situations where claimant was becoming agitated and violent. Claimant was confrontational with other students, whom he believed were talking about him.

4. Over three days in May 2005, neuropsychologist David E. McGee-Williams, Ph.D., conducted a neurocognitive evaluation of claimant. In his report, Dr. McGee-Williams noted that claimant has always had difficulty with staying on task, and he does not retain information well. Also, he has little patience, impulse control or ability to delay gratification. Claimant reported feeling suicidal and hopeless.

Dr. McGee-Williams administered to claimant the Halstead-Reitan Neuropsychological Test Battery for Older Children, from which the Neuropsychological Deficit Scale for Older Children is calculated. Claimant's General Neuropsychological Deficit Scaled score of 40 means that he is not a globally brain-impaired child.⁵ However, in the area of Sensory-Perceptual functions, claimant's deficit score was close to the brain impairment level, and in the area of Visual/Spatial Skills, his deficit score actually exceeded the mean for brain-impaired children. In the area of Dysphasia and Related Variables, complainant's error score exceeded the brain impairment cutoff score. Dr. McGee-Williams testified that claimant's impairments in particular areas go well beyond the learning disability category.

Dr. McGee-Williams noted that, "there was evidence as task demand increases, [claimant] has increasing difficulty sustaining attention and concentration and performing mental work," and "he had difficulty in the area of cognitive flexibility, being unable to switch set rapidly and efficiently."

⁵ The mean score for controls is 30.43, the mean score for brain-impaired children is 67.34, and the brain impairment cutoff score is 43/44.

On the Stanford-Binet Intelligence Scale – Fourth Edition, claimant obtained a Verbal Reasoning IQ of 78, an Abstract Visual Reasoning IQ of 63, a Quantitative Reasoning IQ of 69, and a Short-Term Memory IQ of 81. His Test Composite IQ of 69 placed him in the mentally deficient range of intellectual functioning. In commenting on the individual subtest results, Dr. McGee-Williams stated: “In the area of Short-Term Memory, [claimant’s] visual memory is slightly better for tasks that present overlearned material with cuing. However, with novel visual material and lack of cues (he has to use pure visual memory to perform the task), his scores fell precipitously to a score of 68.”

On the Woodcock Johnson – III, Test of Achievement, claimant obtained a Total Achievement standard score of 80, placing him at the 10th percentile. His broad Reasoning was 86, while Broad Math was 80. His Broad Written Language score placed him at the 30th percentile, but his Math Computational Skills placed him at the 6th percentile. Dr. McGee-Williams believes that claimant’s scores were this high only because of the substantial efforts made by his parents and the school over the years.

Because of claimant’s behavioral issues, Dr. McGee-Williams administered the Millon Adolescent Clinical Inventory (MACI). In his summary and conclusions, Dr. McGee-Williams stated:

. . . [Claimant’s] scores on the MACI really represent this child quite well in terms of his overall discontent, his unhappiness with himself. He is clearly aware of his deficits. He has talked about it, and while he is seen as being depressed and having a pervasive mood disorder, much of this may very well be in response to his own perception of his inadequacies and his lack of intellectual power. Clearly his lack of intellectual power creates a situation in which he simply does not have the ability to create coping strategies for himself when trouble arises and, for an adolescent, we all know that trouble is just around the corner. If one has poor coping abilities, emotional outbursts are frequently the path of least resistance.

Dr. McGee-Williams is certain that claimant has some brain damage. As is generally the case, claimant’s brain damage is accompanied by psychiatric problems. Dr. McGee-Williams does not believe, however, that claimant’s psychiatric problems interfered with his test performance during the evaluation.

Although he made no mention of mental retardation in his report, Dr. McGee-Williams testified that he believes claimant meets the criteria for mental retardation. He conceded that on the surface claimant has better verbal skills than most mentally retarded

persons, but his simplistic and concrete answers to questions are what one encounters with the mentally retarded. Dr. McGee-Williams believes claimant is impaired in the areas of self-direction, learning, communication skills (beyond just talking), capacity for independent living, and self-care (nutrition⁶). Without the tremendous amount of structure and input provided by claimant's school and his parents, Dr. McGee-Williams thinks claimant would "fall by the wayside."

5. Katherine Byrd, claimant's special education teacher during the sixth and seventh grades, testified that claimant was unable to follow the regular curriculum that other students his age followed. At first, there was no special plan for him. But claimant would get very anxious when asked to perform any tasks, and when he was anxious his learning stopped. The school then pulled claimant out for part of the day for a special curriculum which, in the case of math, was not up to his grade level. An inclusion aide was hired to sit with claimant and explain what was happening in simple terms and test him orally on the material to see if he got basic concepts. As a result, claimant "looked better on paper" in most academic areas than he actually could function. And if he appeared to have learned something, it did not mean that he would know it an hour later. His handwriting was such that he could not keep math spatially in order on a page. Claimant never mastered double-digit multiplication and had "no clue" to division. Ms. Byrd testified that claimant is a very nice young man, but he is very intellectually impaired.

6. Psychiatrist Robert E. Soper, M.D., has treated claimant since July 2001. Dr. Soper has tried various psychotropic medications with claimant. His current regimen includes Zyprexa (an antipsychotic), Lithium (a mood stabilizer) and Lexapro (an antidepressant). In his clinical note from June 6, 2005, Dr. Soper listed Axis I diagnoses of Pervasive Developmental Disorder NOS 299.80, "numerous learning disabilities" and "Hx ADD r/o HPAD," and an Axis II diagnosis of Mental Retardation 319.00 (Severity Unspecified). Dr. Soper's assessment was: "High functioning Autism with features similar to Asperger's. At very high risk. Very appropriate for Regional Center and Adolescent Day Rehab and SED [severely emotionally disturbed] or Brain injured." Dr. Soper did not set forth in the clinical note the basis for his diagnoses and assessment, and it appears that he may have been setting forth various diagnostic hypotheses. In a letter to RCRC dated August 22, 2005, Dr. Soper stated that claimant thinks concretely and impulsively, with poor insight and judgment, and "[h]e functions as if he has an IQ in the 60's." In his testimony at the hearing, Dr. Soper opined that claimant is not mentally retarded, but he functions at the level of a person with mental retardation. Dr. Soper believes claimant is impaired in the areas of communication (getting claimant to understand can require patience, sensitivity and oversimplification), learning, self-care (claimant needs reminders to take a bath and brush his teeth, and he has an ongoing problem with caffeine abuse), self-direction and capacity for independent living. Dr. Soper foresees that claimant will not be able to hold a job or manage his money. He considers claimant at high risk for incarceration and methamphetamine abuse.

⁶ Dr. McGee-Williams believes claimant may have a clinical eating disorder. He reported that claimant "has been seen to binge eat, craves sugar and caffeine, and can be a compulsive eater."

Dr. Soper believes the regional center could help claimant by: 1) assisting his psychiatrists once he starts receiving treatment through adult mental health services; 2) providing input and assistance to the legal system if claimant is arrested; and 3) assisting claimant with independent living.

7. On July 21, 2005, school psychologist Leon H. Kent administered the Woodcock Johnson – III, Test of Achievement. Claimant obtained standard scores of 96 (6.8 grade level) in Broad Reading, 69 (3.6 grade level) in Broad Math, and 91 (5.9 grade level) in Broad Written Language. In his Confidential Multidisciplinary Special Education Report Comprehensive Evaluation, dated August 31, 2005, Mr. Kent commented:

[Claimant's] intellectual scores range all the way from average to borderline. During the interview with Jake, he certainly presented as a student with rather normal language and processing skills. He certainly has displayed a wide variety of skills which most likely represent his emotional lability.

8. As of December 1, 2005, when an IEP meeting was held, claimant was enrolled in a regular eighth grade departmentalized program. For his three periods a day in regular classes (science, history and physical education), claimant had a full-time aide to ensure his comprehension and keep him on task. Claimant was in the Resource Specialist Program for his remaining three core classes. On Fridays, claimant worked with his father, an electrical contractor, for school credit. Claimant was able to participate in his science class and complete the assignments with no modification or accommodation. In his other core subjects, he required modification or accommodation of assignments. Only in math was claimant not taught from the eighth grade curriculum. A speech/language therapist provided language processing remediation to assist claimant with verbal communication skills and curricular concept comprehension.

9. After the IEP meeting on December 1, 2005, school psychologist Michael Spangler prepared a Confidential Comprehensive Special Education Multi-disciplinary Reevaluation (Triennial) Report. That report contains the following information about claimant's social/emotional status:

A specific behavior plan has been instituted to assist Jake in attending regular classes and completing academic assignments. Since the beginning of this school year, he has shown steady improvement in emotional stability and academic performance. He continues to vary in his daily motivation to perform school demands, but has shown an improved willingness to receive correction from school staff and persevere despite his bad mood. Although Jake has emotional difficulties and acting-out behaviors, he is primarily well thought of by school staff who

have described him as likeable, amiable, and socially engaging.

10. On December 8, 2005, and January 18, 2006, Michael Spangler and SELPA behavioral specialist Peter Stoll, Ph.D., administered the basic Verbal Comprehension and Perceptual Reasoning subtests of the Wechsler Intelligence Scale for Children – Fourth Edition (WISC-IV). In their Confidential Special Education Addendum Report, dated January 20, 2006, Mr. Spangler and Dr. Stoll explained that on each day of testing, claimant “could only tolerate completing 3 subtests before vocalizing that he had had enough,” and that “[t]he entire battery was not administered so as not to tax Jake with unnecessary involvement in the testing process.” Claimant’s Verbal Comprehension Composite score was 87, and his Perceptual Reasoning Composite score was 90-92. Mr. Spangler and Dr. Stoll stated:

Jake’s performance on these tasks suggested his general intelligence falls within the *low average to average range* of cognitive abilities. In verbal areas, there was very little scatter between subtest scores suggesting consistent development across verbal domains. He showed low average to average abilities in forming verbal concepts, initiating abstract reasoning, expressing vocabulary knowledge, and expressing verbal solutions to social/logical oriented questions.

In perceptual reasoning areas, two subtest scores were consistent with the verbal subtest results (Block Design and Matrix Reasoning) and one scored at the higher end of the average range (Picture Concepts). . . .

For the Block Design task, Jake was required to construct block design patterns using 3-D blocks. Each subsequent design increased in complexity. Jake showed his greatest difficulty on this task and historically visual/spatial reasoning has been an area of weakness. . . . Students who find this task difficult may reflect it in a number of areas such as math reasoning because of the abstract/spatial component involved, letter or number-digit decoding and spelling because of the abstract symbolism involved, letter/number reversals due to the spatial component involved, and visual organization of their personal environment due to the spatial orientation involved.

The Matrix Reasoning task . . . is a measure of general nonverbal intelligence and can be a predictor of a student’s math reasoning ability.

Mr. Spangler and Dr. Stoll made the following remarks in the summary of their report:

Jake was assessed on two separate occasions, by two different examiners he was familiar with, and during a time period (October 2005-January 2006) in which his school adjustment and performance had significantly improved over his status in the spring of 2005. As of this writing, he continues to maintain his behavior and academic performance. It is these examiners' opinion that Jake's emotional status and comfort level had a significant bearing on how he performed on a cognitive assessment such as has been reported here. In the same vein, it would also appear that when Jake is in turmoil, it can and does quickly compromise his potential, although it appears to be temporary in nature.

11. Dr. Drucker is critical of what he calls the "selected test battery" administered by Mr. Spangler and Dr. Stoll. He asserted that the nine WISC-IV subtests that were left out are the type that persons who are mentally retarded or brain-impaired have more difficulty with.

12. In his Confidential Comprehensive Special Education Multi-disciplinary Reevaluation (Triennial) Report, Mr. Spangler stated the following regarding claimant's cognitive functioning and general ability:

It would appear to this examiner, given Jake's ability to participate and contribute at a "sometimes" appropriate level in the regular curriculum and having reading/writing achievement scores that fall within the instructional range for his age group (SS=96 & 91, respectively), that his cognitive abilities probably fall more within a low average range than borderline range. Current teachers reported that given his current performance, he appears to be functioning above a *mild mentally retarded/ borderline* level.

Mr. Spangler also reported that during the IEP meeting, claimant's father stated that "in regards to cognitive functioning, he did not feel Jake displayed disabilities consistent with *mental retardation*." Claimant's father related that claimant had planted some tree seedlings at home and independently set up a maintenance system involving lights, timers and watering. Claimant read pertinent written materials in setting up the system.

13. RCRC consulting psychologist Gerald Drucker, Ph.D., was a member of the

eligibility team that considered claimant's application for services. After meeting with claimant's mother and Dr. Soper, and reviewing the available reports and records, Dr. Drucker was puzzled about the discrepancies in claimant's test scores, e.g., his IQ score of 69 on the Stanford-Binet but his achievement scores in the low average range. Dr. Drucker then arranged to interview claimant. Claimant's mother and RCRC unit supervisor Kathleen Kasmire were present at the interview. Dr. Drucker was impressed with claimant's verbal skills, and claimant did not strike him as being cognitively dull at the level of mental retardation. When Dr. Drucker inquired about claimant's adaptive difficulties, what he heard was that it was claimant's impulsivity, his emotional lability, his paranoia, and his quickness to become aggressive that had been getting him into trouble at school.

Dr. Drucker does not doubt that claimant is substantially handicapped in life skills and that he would benefit from regional center services. (He laments that state and county mental health systems cannot provide the level of support available through the service-rich regional center system.) However, Dr. Drucker does not believe that claimant is eligible for regional center services. In his opinion, claimant is not mentally retarded, and he does not function in a manner similar to a mentally retarded person. Dr. Drucker testified that mental retardation is primarily an intellectual disability, and the adaptive problems of mentally retarded persons are caused by their intellectual deficits. The mentally retarded need repetition to overcome their intellectual deficits – they do not really learn from reading a book or having someone describe a task, but have to be shown how to do something and it has to be repeated. Dr. Drucker finds it incomprehensible that someone who functions like a mentally retarded person could score as high as claimant recently did on the WISC-IV Verbal Comprehension and Perceptual Reasoning subtests, even under the optimal conditions of the testing done by Mr. Spangler and Dr. Stoll. Also, claimant's high achievement scores in one area and his low scores in another do not fit the profile of a mentally retarded person but rather someone with learning disabilities. Dr. Drucker pointed out that psychiatric disorders can impair a person's intellectual and adaptive functioning. In Dr. Drucker's opinion, claimant functions like a person with psychiatric problems and specific learning disabilities. The fact that he may have a neurocognitive disability or brain damage does not make him eligible for regional center services.

14. RCRC medical consultant John Sullivan, M.D., was also a member of the eligibility team in this case. He concurred in the determination that claimant is not eligible for regional center services. Dr. Sullivan agrees that claimant is substantially impaired in his ability to function in life with judgment and self-control, but he believes this impairment is caused primarily by claimant's psychiatric problems and his difficulty in learning and processing information. Claimant's cognitive function, which has been uneven in testing over the years,⁷ is not at the level of mental retardation. Dr. Sullivan thinks that there is probably something wrong with the function of claimant's central nervous system, but that it is beside the point whether claimant's problems are organic. Many people have neurological

⁷ Dr. Sullivan does not know whether claimant's decline in IQ score is "real" or whether it is due to his psychiatric problems, the medications he takes, or the non-prescribed substances he abuses.

problems, but not all of them have a developmental disability. Dr. Sullivan also considered the total pattern of claimant's needs versus the pattern of needs of a mentally retarded person. Claimant's needs center on keeping out of jail, obtaining accommodations at school, preventing emotional blow-ups, and receiving psychiatric treatment and medication. These are not the needs of a person of claimant's age with mild mental retardation.

LEGAL CONCLUSIONS

1. The governing law is found in the Lanterman Developmental Disabilities Services Act,⁸ under which "[t]he State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge."⁹ The Legislature has created a comprehensive scheme to provide services and supports for persons with developmental disabilities, with a twofold purpose: (1) to prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community;¹⁰ and, (2) to enable developmentally disabled persons to approximate the pattern of living of nondisabled persons of the same age and to lead more independent and productive lives in the community.¹¹

2. The services provided by regional centers under the Lanterman Act are not available to every person with a physical or mental handicap who is in need of assistance. Rather, a person must be developmentally disabled within the meaning of the following statute:

"Developmental disability" means a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. . . . [T]his term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.¹²

⁸ Welf. & Inst. Code § 4500 et seq.

⁹ Welf. & Inst. Code § 4501.

¹⁰ Welf. & Inst. Code §§ 4501, 4509 & 4685.

¹¹ Welf. & Inst. §§ 4501, 4750 and 4751; see generally *Association for Retarded Persons v. Department of Developmental Services* (1985) 38 Cal.3d 384, 388.

¹² Welf. & Inst. Code § 4512, subd. (a).

To constitute a substantial disability, the condition must result in “major impairment of cognitive and/or social functioning.”¹³ This is further explained as follows:

Since an individual’s cognitive and/or social functioning are many-faceted, the existence of a major impairment shall be determined through an assessment which shall address aspects of functioning including, but not limited to:

- (1) Communication skills;
- (2) Learning;
- (3) Self-care;
- (4) Mobility;
- (5) Self-direction;
- (6) Capacity for independent living;
- (7) Economic self-sufficiency.¹⁴

Specifically excluded from the definition of developmental disability are handicapping conditions that are solely psychiatric disorders, solely learning disabilities, or solely physical in nature.¹⁵

3. Claimant does not suffer from mental retardation. Dr. McGee-Williams’s assertion at the hearing (but not in his report) that claimant meets the criteria for mental retardation appears to be based on claimant’s IQ score of 69 on the Stanford-Binet. One of the diagnostic criteria for mental retardation is significantly subaverage general intelligence functioning, which is defined as an IQ of about 70 or below.¹⁶ However, claimant’s IQ score six years earlier was 82; his achievement scores have been in the average to low average range; he has never been identified as mentally retarded; his psychiatrist does not believe claimant is mentally retarded; and the level of claimant’s verbal skills and general functioning is above what would be expected of a mentally retarded person.

4. Claimant does not suffer from a condition similar to mental retardation or requiring treatment similar to that required by mentally retarded individuals. He is capable of intellectual functioning, particularly in verbal areas, in the low average range. However, claimant has serious psychiatric problems as well as some difficulty in learning and processing information, and these challenges are at the root of the emotional instability and behavior problems that interfere with his intellectual and social functioning. During the most

¹³ Cal. Code Regs., tit. 17, § 54001, subd. (a).

¹⁴ Cal. Code Regs., tit. 17, § 54001, subd. (b).

¹⁵ Cal. Code Regs., tit. 17, § 54000, subd. (c).

¹⁶ Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – Text Revision, p. 41.

recent academic year, the school's behavior plan for claimant resulted in a substantial improvement in his emotional stability and school performance. Claimant was able to participate in a regular science class and complete the assignments without modification or accommodation. At home, he was able to set up a complicated plant maintenance system. Although it is unknown how claimant would have scored on the WISC-IV subtests Mr. Spangler and Dr. Stoll did not administer, claimant's scores on the subtests that were administered in December 2005 and January 2006 suggested that his general intelligence is within the low average to average range. Although claimant is substantially impaired in life skills, and requires great support from his family and the school, it was not established that he suffers from a condition similar to mental retardation. And his treatment needs are not similar to those of mentally retarded individuals.

5. There is no doubt that claimant has serious problems which place heavy demands on his family and the school. Claimant and his family could benefit from some of the services offered by the regional center, but it is not possible at this time to conclude that claimant meets the eligibility requirements under the Lanterman Act.

ORDER

Claimant Jake V.'s appeal to be found eligible for services from Redwood Coast Regional Center is denied.

DATED: _____

NANCY L. RASMUSSEN
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision in this matter. Judicial review of this decision may be sought in a court of competent jurisdiction within 90 days.